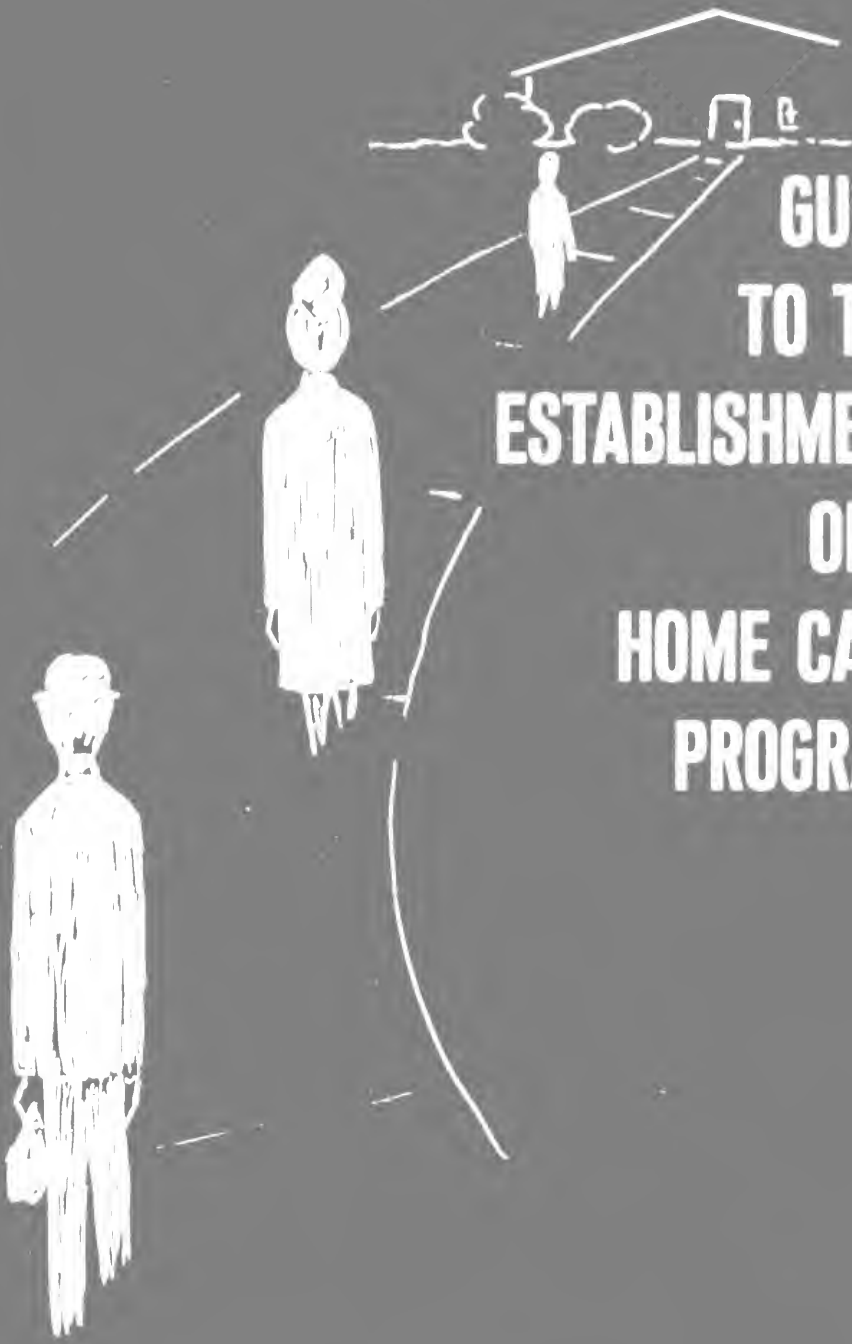

GUIDE TO THE ESTABLISHMENT OF A HOME CARE PROGRAM

Joint Committee
State Medical Society
State Nurses Association
State Board of Health
of North Carolina

Guide to the Establishment of a

HOME CARE PROGRAM

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State Medical Society
State Nurses Association
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HERITAGE PRINTERS
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FOREWORD

There is an increasing need and demand for health care and health maintenance for the citizens of our state. Some of the factors influencing this need are the increasing number of older citizens, the increase in incidence of chronic and long-term illnesses, the broader use of hospital care plans and a more knowledgeable public that desires and seeks more and better health care. This situation demands a dynamic approach to providing comprehensive health services. Need for varying levels of intensity of care must be recognized.

The Medical Society of North Carolina has had for several years a committee on chronic illness, whose purpose it has been to identify its responsibility and implement ways of meeting these increasing problems. The North Carolina State Nurses Association has had for three years a Committee on Nursing Care of the Chronically Ill and Aged. In June of 1962 these committees met together to discuss common problems, responsibilities, and purposes. The group quickly recognized as one of our greatest needs in North Carolina the expansion of care of the sick in the home. Such a program, well planned and well executed, extends the arm of the physician, through the use of para medical and other auxiliary personnel, in many directions, meeting patient and family needs which he cannot possibly meet alone.

Some of our communities now have home care programs in operation, but many others have not yet visualized their potential value, or are still looking for direction and guidance in the establishment of such programs.

For communities that are looking for direction in determining their own health care needs and means of improving health care services through home care programs, this guide has been developed. As the name implies, this booklet is only a **guide.** It has been developed with North Carolina's needs and resources in mind. We hope it will be useful to local communities which can adapt it, in whole or in part, to the special needs of each.

The sub-committee to which was delegated the task of developing this tool quickly recognized the need to include the State Department of Health in the undertaking and requested its assistance.

Those working on the guide were: Dr. Daniel A. McLaurin, Dr. T. D. Long,

Dr. O. David Garvin, Dr. D. F. Milam, Mrs. Nan Cummings, Miss Ethel Harrison, and Mrs. Mary Edith Rogers. A strong supporter of the project was Dr. Thomas R. Nichols, chairman of the Medical Society Committee on Chronic Illness, and many other groups and individuals contributed to the content.

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May 1, 1963

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PLANNING HOME CARE

A Community Guide

I. INTRODUCTION

A. Description

1. Home Care is the provision of services to selected patients in their homes through the coordinated efforts of community agencies and organizations. Services are prescribed by the physician and carried out under his direction. They may include any one or combination of the following: nursing, physical therapy, homemaker, social service, and other services as indicated and available.
2. Treatment of illness — chronic or otherwise — may require, at one time or another, acute hospital care, intensive rehabilitation services, skilled nursing care in a nursing home, out-patient care and/or coordinated medical care in the patient's home.
3. For some patients, adequate care in the home requires personal assistance that a member of the family can give, under the supervision and direction of the family physician. For others it may be necessary to supplement this care with the assistance of a visiting nurse, as well as direct care from specialists in various areas such as physical, occupational, or speech therapy, and from other disciplines. The organization of these various skilled services into a centrally administered program is called "Home Care."
4. The services may be available to the young, the middle-aged, and the old, the short-term patient and the long-term chronically ill patient. If a physician feels his patient can convalesce better in his own home, if the patient and his family want the service, and if the home environment is conducive to good convalescence, then the physician may request services of a Home Care Program. This care should be available to those able to pay as well as to the indigent.

B. **Comments on Administration and Financing**

1. Home Care programs may be administered by a Public Health Department, a Visiting Nurses Association, a hospital, or a combination of these organizations.
2. The needs and resources of the local community will determine method of operation and services rendered.
3. The patient and his family may pay for home care on a basis of fees for services. Some pre-payment programs, such as Blue Cross Insurance, include payments for home care in their benefits. Local health, welfare, and other governmental organizations, as well as voluntary health agencies and community organizations, may pay part of the cost of care.

C. **Value to Patient and Community**

1. Frequently hospitalization can be avoided if the patient can be effectively treated at home. By providing hospital care only for those who need total hospital care, more effective use can be made of community facilities. This could reduce the demand for additional hospital beds in some communities.
2. Continuous care of patients upon leaving the hospital facilitates rehabilitation to the patient's maximum functioning capacity within his home environment.
3. Many patients are happier, recover more quickly, and, in the case of chronic illness, many respond more satisfactorily at home.
4. Home care cuts down on the over-all cost of medical care and is less expensive than hospitalization.
5. Preservation of family unity, which is often disrupted by long illnesses, is a significant potential of home care programs.

II. POINTS TO CONSIDER IN ORGANIZING A HOME CARE PROGRAM

Regardless of the organizational pattern that may develop in a given community, points listed below, not in any order of priority, would seem to be important.

A. **Fact Finding**

1. Determine the Interest In and Need for a Home Care Program
   a. Patients known to physicians who might be helped by Home Care services.

b. Patients in hospitals and other institutions who might be returned to their own homes.

2. Determine the Resources Available
   a. Personnel to provide services (official, voluntary or private)
   b. Facilities, equipment and supplies
3. Determine the Interest and Cooperation of Community Groups
   a. Medical Society
   b. Dental Society
   c. Health Department
   d. Welfare Department
   e. Hospital and other Institutional Facilities
   f. Voluntary Health Agencies
4. Determine Interest of and Secure the Approval of Local Governmental Bodies
   a. Board of County Commissioners
   b. City Council or Equivalent Group
   c. Board of Health
   d. Board of Public Welfare

B. **Establish Advisory Council**

1. Composed of Representatives of Interested Agencies
   a. Medical Society
   b. Dental Society
   c. Nurses Association
   d. Physical Therapy Association
   e. Health Department
   f. Welfare Department
   g. Hospital
   h. Voluntary Health Agencies
2. Functions
   a. Determine administering unit and delegate thereto appropriate responsibillity and authority
   b. Establish policies
   c. Plan and evaluate program
   d. Coordinate activities

C. **The Administering Unit**

1. Medically Oriented and Physician Directed

2. Preferably, The Local Health Department
3. Alternate Administering Units May Be —
   a. Voluntary health agency (i.e., V.N.A.)
   b. Combination health agency
   c. Especially incorporated agency
   d. Independent contract (individual practitioner)
   e. Hospital

III. OPERATIONAL POLICIES AND PROCEDURES

A. Define Aims of Program, As

1. Shorten hospitalization
2. Avoid readmission
3. Provide maximum non-institutional care
4. Reduce costs of illness

B. Determine Services to be Offered, As

1. Nursing
2. Physical therapy
3. Homemaker
4. Nutrition
5. Other — Depending upon community resources and needs, other services may be indicated and possibly developed, as
   a. Occupational therapy
   b. Speech therapy
   c. Social Service
   d. Vocational Rehabilitation
   e. Recreation
   f. Ministerial counseling
   g. Education

C. Establish Criteria for Acceptance of Patients, Such As

1. Can the illness be adequately and safely cared for in the home?
2. Is the patient's home suitable?
3. Is someone in the home able and willing to assume responsibility for the patient?
4. Does the patient and/or his family want the service?

D. **Develop Medical Policies**

See Appendix A for details of physician participation in the Home Care Program.

E. **Develop Policies Relating to Other Services**

Policies and standards should be developed for services which will be provided (i.e. nursing, physical therapy, etc.). For details of specific suggested standards of nursing care and physical therapy, see Appendix B and C.

F. **Establish Methods and Techniques of Communications**

1. Facilitate interchange of information and factual case reporting
2. Assure coordination and maximum, appropriate use of service

IV. FINANCING

A. **Establish a Plan for Financing Program**

1. Establish the cost of the proposed service
2. Determine the sources of funds
3. Establish a fee schedule for services rendered, including a guide for part payment
4. Formalize plans for accepting fees (either by the agency providing the service or by a sponsoring group)

B. **Develop Policies Relative to Procurement and Handling of Drugs, Supplies, and Equipment**

V. RECORDS

Establish a record system which will:

A. **Facilitate Continuity and Coordination in Services Provided, As**

1. Referral form which includes physician's diagnosis and orders
2. Patient and family record
3. Report to physician on care rendered
4. Index card summarizing information about patients currently receiving care

B. **Yield Statistical and Cost Data Needed to Meet Administrative, Operational, and Evaluative Needs in the Program, As**

1. Unduplicated counts of the number and kinds of patients served in a given period

2. The number of new admissions and re-admissions
3. The amount and types of services provided
4. The cost of operating a home care program

VI. EDUCATION

The items determining the success of the program (under VIII. Summary, below) are largely a measure of the extent and success of educational efforts. Involving people in the planning, education, and service elements of the program is the best method of educating and thereby maintaining support and interest. Therefore, plan to involve a wide area of community interest from the beginning.

A. Targets for Education

1. Professional Personnel
   a. Wide involvement in determining needs, planning, and evaluation
   b. Early interpretation of program to each physician
   c. Interpretation of program to other professionals, hospital and agency staffs
   d. Continuous reporting of program progress and needs
   e. On-going education regarding chronic diseases and improved techniques of home care
2. The Patient and His Family
   a. Interpretation of (1) what the program is, what services he can obtain; (2) his particular condition; (3) how to carry out treatment instructions
   b. Motivation to follow through
3. The Community at Large (including such special groups as County Commissioners, Boards of Health and Agency Boards)
   a. Interpretation through individual and group contacts and mass media of (1) need for a program; (2) the program; and (3) program progress.
   b. Involvement of key lay persons in planning
   c. More widespread lay involvement in planning, developing, and carrying out supporting services, such as transportation, loan closets, friendly visitor services, workshops on recreational activities for the homebound

B. **The above items of education should be carried out by the appropriate professional personnel.** Public Health Educators, employed locally or

brought in on a consultation basis, can assist in such activities as planning, coordinating, and publicity.

VII. EVALUATION

Provision should be made for periodic evaluation of the program.

A. **Have the techniques for introducing the program been successful, as indicated by**

1. Community response to the program
   a. Professional interest
   b. Support of voluntary and official agencies and organizations
   c. Private citizen interest and request for services
2. Utilization of services, as
   a. Cases referred and admitted to service
   b. Degree of continuity of care and quality of care
   c. Number of physicians referring patients

B. **Are objectives being achieved, as stated in I, C — Values to Patient and Community, and III, A — Aims of Program**

C. **Financial Review**

1. Estimated cost of total program
2. Unit cost
3. Has there been a reduction of cost of illness for patients; for community?

VIII. CONSULTATION SERVICE

In planning, organizing, and carrying out a home care program, help can be obtained from the following State agencies and organizations:

A. **State Medical Society**

Through headquarters staff and appropriate committees

B. **State Nurses' Association**

Through headquarters staff and appropriate committees

C. **North Carolina Physical Therapy Association**

D. **State Department of Health**

1. Chronic Disease Section
2. Health Education Section (for organization planning, as well as for planning educational aspects)

3. Public Health Nursing Section
4. Nutrition Section
5. Physical Therapy Consultants
6. Records Consultants

E. **State Department of Public Welfare**

1. Child Welfare Consultant
2. Consultant in Services to the Aged
3. Homemaker Supervisor

F. **The Medical Schools of the State and the School of Public Health at the University of North Carolina,** through Continuation Education Programs, can often offer in-service education for professional groups. Interested communities might find these schools a good resource in helping to plan this type of community health service.

IX. SUMMARY

The above represents in broad scope the essentials in the organization of a Home Care Program either for the medically indigent or those private patients who will benefit thereby.

A. **The Success of the Program Will Be Determined by**

1. Community's recognition of the need
2. Physician's utilization of the services for his patients
3. Patient's acceptance and desire for care and the family's cooperation
4. Degree of enthusiasm and cooperation of the coordinating agencies

B. **Although a Home Care Program is administered as a community project,** it remains but another modality of treatment of a sick patient. Medical direction of the program and medical supervision of the patient are therefore essential.

APPENDIX

APPENDIX A — PHYSICIAN PARTICIPATION IN A HOME CARE PROGRAM

I. **For a successful and continuing Home Care Program** there must be physician participation and direction. This requires the approval, support and patronage of the private practioner in the community.

II. **Independent Responsibility of the Private Physician.***

A. Identify patient's need for home care

B. Make referral to administering agency and request service

C. Indicate on referral form the diagnosis and specific categories of care needed. Indicate if this is a private or medically indigent patient. (If economic status is not known he may request appropriate welfare evaluation.)

III. **Team Responsibility of the Physician.**

A. Attend and give leadership in initial conference with home-care personnel to:

1. Outline needs of patient and family
2. Evaluate program resources to meet these needs
3. Designate services to be rendered, such as:
   a. Nursing
   b. Physical therapy
   c. Nutrition
   d. Social work
4. Interpret physician's orders and formulate an outline of prescribed therapy, immediate and long range

B. Maintain open lines of communication with service personnel to:

1. Assure the protection of physician-patient relationship
2. Assure that physician has knowledge of all pertinent developments in the patient's care and his condition

C. Participate in periodic re-evaluation conferences at specific intervals or according to need.

IV. **Physician-Patient Responsibility**

A. Indicate alternate physician to be contacted in the event of temporary absence of the attending physician.

*Provision should be made for medical supervision of medically indigent patients, either by patient's choice of physician, or by assignment to the county physician, or to community physicians serving on a rotating basis.

APPENDIX B — NURSING SERVICE IN A HOME CARE PROGRAM*

I. **The quantity of nursing care available in the home** is dependent upon the ability to recruit and retain qualified personnel within an organizational framework which permits full utilization of available nursing resources.

II. **Definitions**

A. Registered Professional Nurse. — A registered professional nurse in North Carolina is one who has completed satisfactorily a two-year, three-year, or a four-year course of study in an accredited school of nursing and has successfully passed the required licensing examination. A nurse may be registered in North Carolina without examination only when the applicant has been duly licensed as a registered nurse by examination under the laws of another state, and if in the opinion of the North Carolina Board of Nurse Registration and Nursing Education the applicant is competent to practice as a registered professional nurse in this state.

B. Licensed Practical Nurse. — A licensed practical nurse in North Carolina is one who has met all the requirements of the law and received a license to practice practical nursing in North Carolina. The LPN shall have satisfactorily completed a course of study in a state or nationally accredited practical nurse program or shall have been licensed by waiver.

III. **Qualifications**

A. Graduation from a State or Nationally Accredited Program of Nursing Education.

B. Current licensure to practice nursing in the State of North Carolina.

C. Good physical and mental health

IV. **Nursing Responsibility**

The professional nurse is responsible for the nursing care of the patient in the home. She discharges her responsibilities under the direction of the patient's physician. She has knowledge, skills, and understanding in the principles of nursing and in fields related to medicine which prepare her to:

A. Plan, direct, and give nursing care.

B. Make periodic observations of her patients to ascertain their needs and plan care accordingly.

*Guilford County Health Department has recently prepared a Nursing Procedure Manual which has been approved by a Nursing Committee on Procedure for state-wide use.

C. Perform nursing care requiring professional competence.

D. Supervise the performance of skills and techniques for nursing care which may be delegated to other nursing personnel.

E. Make and report those clinical observations important to the physician.

F. Assist in providing for comprehensive and continuing care of the patient by utilization of services of other health disciplines when this is indicated.

V. **Agency Responsibility**

A. The agency administering the program has the responsibility for maintaining standards consistent with acceptable practice and for assuring the provision of adequate and safe care. Standards should include:

1. Medical orders in writing and signed by the physician
2. Policies relating to the control of prescribed medicines and treatments in writing, defining frequency of medical review and the recording and renewal of orders. Policies should have the approval of the responsible medical group.
3. A nursing record for each patient. The registered professional nurse should be responsible for the accuracy of the reporting and recording of the patient's symptoms, reactions, and progress.
4. Written policy and procedure manuals which are kept in line with currently approved nursing practices.

B. The agency administering the program should provide written personnel policies. There should be job descriptions, plans for orientation of new staff, and provision for in-service education. Employment standards should be consistent with those recommended by the State Nurses Association.

APPENDIX C — ROLE OF THE PHYSICAL THERAPIST IN A HOME CARE PROGRAM*

I. **Qualifications**

A. Graduation from an approved School of Physical Therapy.

B. Registered by the North Carolina State Examining Committee of Physical Therapists.

*Reference: "Elements of Co-operative Home Care for the Chronically Ill," North Carolina Physical Therapy Association — 1962, Committee on Chronic Illness, Helen Kaiser, Chairman, Duke University Medical Center, Durham, N. C. Submitted through the North Carolina Physical Therapy Association, Inc., by the Committee on Chronic Illness.

II. **Responsibilities**

A. Direct Service. Physical therapy as prescribed by the attending physician.

B. Supervision. Procedures prescribed by the physician and initiated by the physical therapist to be carried out by the family or related health personnel.

C. Instruction. Teaching of physical therapy management and procedures to patient, family, and related health personnel through:

1. Direct assistance
2. In-service training in:
   a. Positioning
   b. Maintenance of motion
   c. Transfer activities
   d. Ambulation
3. Demonstrations
4. Visual aids
5. Printed matter
6. Workshops and seminars

D. Consultation. Participation with other health personnel in:

1. Preliminary assessment and care of patient
2. Establishment of goals
3. Development of program
4. Utilization of community resources
5. Evaluation of patient progress
6. Plans for follow-up

APPENDIX D — HOMEMAKER SERVICE IN A HOME CARE PROGRAM

I. **Definition of Homemaker Service**

Homemaker service is a community service sponsored by a public or private health or welfare agency that employs personnel to provide housekeeping and such personal services as are required by individuals who, because of infirmity, disability, or illness, would be unable otherwise to remain in their own homes. Although homemaker service was started in voluntary agencies serving families with children, tax supported agencies were soon to recognize the value of this service, and since 1958 the number of homemaker service programs in public welfare agencies has more than doubled. With the aid of federal matching funds it is now possible for a homemaker service program to be de-

veloped in any community through the cooperation of the state and local public welfare agencies.

II. **Development of Homemaker Service in North Carolina Under Public Welfare**

The North Carolina State Welfare Department, with its history of development of public social services, pioneered in homemaker service in 1947. For the first few years the service was available only to families with children. However, with an awareness of acute need for this service for the aged, the chronically ill, and the disabled, and being especially concerned over the increasing number of adults remaining for unnecessarily long stays in hospitals or being placed in boarding and nursing homes because of the lack of someone to give assistance with the daily chores in their own homes, homemaker service for adult care was developed.

III. **Philosophy of Homemaker Service in a Public Welfare Agency**

Homemaker service provides qualified persons who are trained and supervised to carry responsibility for the care and management of the home. The homemaker is responsible to the public welfare agency which employs her, and the state and county departments of public welfare share in the responsibility for this service.

Homemaker services are available only in conjunction with casework services. The decision to use homemaker service is reached on the basis of careful casework study of each case. The individual or family is assured of their right to accept or reject the service after the conditions under which it is available have been explained to them. There must be mutual understanding and agreement between the individual or family, the homemaker, homemaker supervisor, caseworker, and the referring physician or nurse as to just what the homemaker will do and hours of service to be provided.

IV. **Qualifications**

A homemaker for the aged, chronically ill, and disabled must be emotionally mature, capable of assuming responsibility, warm and outgoing. She should have a positive philosophy toward the aging and their potential for a continuing satisfying life. She must be able to give help and sympathetic understanding to enable the aged person and the ill and disabled to regain or sustain the highest possible degree of independent living. She must respect the confidential nature of her job. She must be able and willing to learn through her job experience, capable of working with the caseworker and other professional persons such as a doctor, nurse or physical therapist, coming into the home.

A homemaker must be reliable and competent in household management and should have had experience in the purchase and preparation of food. Good physical health is essential.

Emphasis is placed on personal qualities rather than formal education. The North Carolina Merit System requires that homemakers employed by the county department of public welfare have at least an elementary grade education.

V. **Duties and Responsibilities**

In general these are the tasks a homemaker would be expected to perform:

A. Clean house, including sweeping and dusting, but not heavy seasonal housecleaning.
B. Buy groceries and other items.
C. Plan and prepare meals.
D. Help in working out a budget.
E. Give baths and help with personal appearance of individual with such services as shampoo, shave, trimming nails, etc.
F. Do light laundry, but not heavy family laundry.
G. Mend clothing and household supplies.
H. Help patient follow treatment plans prescribed by the doctors, such as use of wheelchair, walker or crutches, and exercises.
I. Encourage the aged or disabled person to help himself insofar as possible.
J. Teach the person to carry out certain household tasks.
K. Read to, or otherwise stimulate the interest of the person.
L. Serve as a cheerful, helpful companion.

APPENDIX E — THE ROLE OF THE NUTRITIONIST IN A HOME CARE PROGRAM*

I. **A nutrition consultant can assist with the home care programs in your county.** Call on her to:

A. Plan with the staff of the health department in developing the nutrition component of the home care program.
B. Interpret to members of the home care team the contributions she may be able to make in giving total care to the patient.
C. Participate in in-service education programs on the subject of home care.
D. Assist in obtaining a diet history from the patient, in evaluating the

*Nutrition Section, N. C. State Board of Health

patient's eating habits, and in interpreting dietary goals desirable for the patient.

E. Provide information regarding a therapeutic diet prescribed for the patient.

F. Act as resource person to help the home care team keep up-to-date on nutrition education materials, dietary information, and new research developments.

II. **At the request of the physician or the public health nurse, the nutritionist may assist in:**

A. Counselling with the patient and his family regarding therapeutic diet prescribed as part of treatment, or needed improvements in eating habits generally.

B. Helping family members to adapt the therapeutic diet of the patient to their economic standards and eating patterns.

C. Giving guidance to the family in meeting needs of the patient with feeding problems such as inability to feed self, need for special devices, or inability to chew.

APPENDIX F — METHOD OF APPLICATION FOR HOME CARE PROJECT GRANT*

History of the Program

On July 15, 1962, the State Board of Health began accepting applications from county health departments for grants-in-aid for specific programs in Care of the Chronically Ill at Home. Funds for this purpose were made available by Congressional appropriation in 1961 and subsequently. These grants are available only to local health departments and are designed to make possible the organization or extension of this activity by the local agency through the addition of new personnel, chiefly nurses and physical therapists. The additional staff time required to carry out this program by the whole department staff would roughly equal that of the new personnel whose employment was made possible by the grant. In no case are nurses to be employed whose duties would be limited solely to the home nursing program.

Purpose

The prevention of progressive disability of the chronically ill is the main purpose of the program, with cure, rehabilitation for employment or restoration to self care as additional possibilities. Community values include freeing of hospital beds

*From the North Carolina State Board of Health

for occupancy by the acutely ill, reduction of welfare costs for preventable dependency (including hospitalization or nursing home care), and the provision of home medical care for a large group in the community who now fail to receive needed medical care. While the home care must now be furnished free to all patients, it is hoped for early authorization to collect fees from those able to pay.

Applications

Applications for a project grant when ready are to be sent to the Section of Chronic Diseases, State Board of Health. There are two parts to the application; first, a survey of the county giving available general information pertinent to the problem, including demographic data (available or informed estimates) on the number of chronically ill and aged, and the extent to which their care is neglected; and, secondly, a listing of the facilities locally available for the care of the chronically ill by public or private health agencies, and a description of the unmet needs of the community. Also to be included is a detailed plan on how the requested grant would be utilized to meet these unmet needs.

Contract

With this survey as background, a contract is drawn up for signature by local and state health officials. This contract lists in detail the services that will be provided by the county health department under this contract, and emphasizes that the program will be carried out only for patients referred by the personal physician of each patient admitted and followed under his continuing care. Adequate reports to justify expenditures for the specific programs and to evaluate results will also be furnished. The State Board of Health contracts to furnish funds sufficient to cover expenses of the new program, which are outlined in the budget. The duration of the contract is for one year, renewable on negotiation for two additional years if government funds are made available and results justify the extension in each case. Project grants will vary from $6,000 to $15,000, depending on population, need, and expansion proposed. In every contract some provision for physical therapy should be made. Its inclusion in the plan for home care services is a very important item for acceptance.

Conditions

Three main conditions are pertinent to applications before coming up for approval: (1) That the program has the officially recorded approval of the county medical society, (2) that it has the interest and encouragement of the local health director and his staff, and (3) that the county is already covering with reasonable adequacy, its basic needs for public health nursing.

NOTE

Funds available for home care projects in 1962-63 budget year were approximately $200,000. This entire sum for the present year has now been allocated on eighteen contracts made on applications received before the end of the half year.

Additional Notes

Details of the Program of Grants for Home Care of the Chronically Ill

1. Compliance with the requirement of previous adequacy of coverage of basic needs for public health nursing will be considered as met when the public health nursing staff of the county health department is not less than one nurse per 5,000 population. This condition is abated if reasonable coverage in relation to the local economy is proven, and no extra burden will be placed on the staff if the grant is made.
2. The State Board of Health grant is aimed at providing more nursing time for each of the public health nurses to provide more nursing services to the chronically ill. The addition of a single nurse to the local staff should permit the entire staff to accomplish more in this line than one person devoting full time to this service.
3. The maximum sum of money available for a grant to a county of 50,000 population is tentatively set at $15,000. This may be used for the salary of one or more public health nurses, a physical therapist, travel, supplies, and office expenses of this program. Smaller counties should count on smaller sums.
4. Fees for this nursing service cannot now be legally collected by health departments. Since the service is expensive and needs to be extensive, it is hoped a way will eventually be provided for collecting fees from those able to pay for this service. A private organized group might be able to collect fees and thus provide additional funds to the health department for needed nurse salaries. A sliding fee scale has proved effective in other areas.
5. In any county a program for home care of the chronically ill should be designed to fit the needs, wishes, and resources of the individual county. No prearranged plan is suggested. When a grant is made by the State Board of Health for such a project a contract is signed with the county health department, covering the items agreed upon.
6. Please communicate with the Chronic Disease Section of the State Board of Health for further information if needed. And don't delay in formulating proposals if the present budget year is being considered.

SURVEY FORM — STATE BOARD OF HEALTH

COUNTY HOME CARE PROJECT PLAN

SUGGESTED OUTLINE

A. **Problem**

1. Estimate the number of persons in the county subject to disability from chronic disease; some estimated percentage of these not now receiving care at home who could be expected to benefit from such care.
2. Scope of services currently available
   a. Visiting Nurse Association
   b. Health Department
   c. Any other private health agency
3. Needs unmet by currently available services

B. **Objectives**

1. List of those needs outlined in A. 3 above which the project will strive to meet.

C. **Available Resources**

1. List staff
   a. Specialties represented
      (1) Doctors
      (2) Nurses
      (3) Physical Therapists
         (a) Hospitals
         (b) Private Practitioners
         (c) Health Department
         (d) Available for part-time work
      (4) Clerks, etc.
   b. Current Workload
      (1) Population per nurse
      (2) Current number of home visits to chronically ill patients per year
      (3) Current number of home visits to chronically ill patients per nurse per year
   c. Anticipated increase in total number of home visits to chronically ill patients
      (1) Increase should exceed number of nurses added to staff by this proj-

ect, multiplied by average number of visits to chronically ill patients per nurse. (See (3) above)

2. List available facilities and equipment
   a. Adequate space in Health Department building
   b. Special equipment such as
      (1) Physical therapy devices or disability aids
      (2) Special literature
      (3) Other

D. **Procedures**

1. Narrate manner in which staff will be utilized to meet objectives under B.
   a. Roles of:
      (1) Local Health Director
      (2) Nursing Staff
      (3) Physical Therapist
      (4) Other personnel and groups

E. **Evaluation:**

1. Indicate types of reports which would be useful in evaluating the effectiveness of the project.
   a. Number of patients served (broken down by diagnosis)
   b. Total nursing visits
   c. Narrative analysis of project effectiveness based on success or failure of procedures to attain project goals

F. **Budget**

1. Salaries, Social Security, etc.
2. Travel
3. Miscellaneous expenses

SPECIMEN RECORD FORMS

PHYSICIAN'S ORDERS

Date .....

TO: The Nursing Division of the . County Health Department.

Patient's Name .....

Address .....

Diagnosis .....

Medication .....

(Name) (Amount)

.....

(Method of Administration) (Frequency)

Treatment .....

(Be Specific) (Frequency)

.....

Date to Begin

Renew ..... Date to Terminate .....

Remarks or Comments That May Be Helpful to Nurse in Giving Service .....

.....

.....

.....

(Signature) ..... M.D.

All orders to be renewed in writing every 3 months.

REFERRAL TO HOME CARE PROGRAM

Person/Agency to Which Referred Date

Person Agency Initiating Referral

Patient's Name Birthdate Sex Race

Husband or Wife Address

Specific Directions:

Patient: Home Hospital

Brief Medical History and Physical Findings

Prognosis

Medications Now Being Taken by Patient

Physician's Orders/Request

Specific instructions given to: Name

Address Relationship

Signed: M.D.

Date: Address:

CHRONIC DISEASE PROJECT — PERSON COUNTY*

C. D. Form — Work Sheet

Patient's Name ..... Family Physician .....

Address ....

Date .....

Time Spent in Travel ..... No. Miles Traveled .....

Time Spent in Actual Visit .....

Classification .....

Services Rendered and Comments:

Signature .....

Date Next Visit Planned .....

(To be used as a "Tickler File")

*Form used in Person County Home Care Program — by any service personnel.

Name (Last) (First) (Middle) Birth Date Race Sex Discharge

Address Referral Date Admission Date Discharge Date

Primary diagnosis Death Date

Other disorders

Physician Nurse Last Call Status

Year	Visits					Conference Dates		Patient Progress			
	MD	PHN	PT	MSW	Nutr.	Last	Scheduled	Remarkable	Improving	Static	Regressing
Jan.											
Feb.											
Mar.											
Apr.											
May											
June											
July											
Aug.											
Sept.											
Oct.											
Nov.											
Dec.											

Year	Visits					Conference Dates		Patient Progress			
	MD	PHN	PT	MSW	Nutr.	Last	Scheduled	Remarkable	Improving	Static	Regressing
Jan.											
Feb.											
Mar.											
Apr.											
May											
June											
July											
Aug.											
Sept.											
Oct.											
Nov.											
Dec.											
Jan.											
Feb.											
Mar.											
Apr.											
May											
June											

Patient Summary Card, Person Co. Chronic Disease Project, 10-60

Record form used by Person County Home Care Program and adopted by the North Carolina Department of Health. The form utilizes a 5 x 8 inch index card.

REFERENCES

American Nurses' Association, **Functions, Standards and Qualifications for Practice,** A.N.A., 10 Columbus Circle, New York 19, N. Y.

Bryant, Zella, R. N., M.P.H., **Report on Nursing Care of the Sick at Home** — (in incorporated cities of the U. S. with population of 25,000 and over) Dept. of H.E.W., P.H. Service Publication No. 901, U. S. Gov't. Printing Office, Washington 25, D. C.

Guilford County Health Dept., **Nursing Procedure Manual,** Guilford County Health Dept., Greensboro, N. C. - High Point, N. C.

National League for Nursing, **Report on a Work Conference on Nursing in Long-Term Chronic Disease and Aging,** N. L. N., Code No. 14-803, 10 Columbus Circle, New York 19, N. Y.

National League for Nursing, **Community Nursing Services,** N. L. N., 1962, 10 Columbus Circle, New York 19, N. Y.

New York State, **Care of the Sick at Home,** 1961 N. Y. State Dept. of Health, Albany, N. Y.

North Carolina Physical Therapy Association, **Elements of Cooperative Home Care for the Chronically Ill,*** 1961-62, N. C. Physical Therapy Association.

Ohio Medical Association, **Suggestions for a Community Home Care Program,** Ohio State Medical Association, Committee on Care of the Aged, 1962, 79 East State Street, Columbus 15, Ohio.

Smith, Louise C.,† **Factors Influencing Continuity of Nursing Service,** N. L. N., 10 Columbus Circle, New York 19, N. Y.

U. S. Department of Health, Education and Welfare, **Homemaker Service in Public Welfare,** The North Carolina Experience, 1961 — 0-618664, U. S. Gov't. Printing Office, Washington 25, D. C.

U. S. Department of Health, Education and Welfare — **Public Health Monograph No. 35** — A Study of Selected Home Care Programs — U. S. Gov't. Printing Office, Washington 25, D. C.

U. S. Department of Health, Education and Welfare, **Summary Report of the First Regional Workshop on Home Care** — sponsored by AMA, AHA, USPHS, Blue Cross Association, National Association of Blue Shield Plans — May 25-26, 1961. U. S. Gov't. Printing Office, Washington 25, D. C.

U. S. Department of Health, Education and Welfare, Public Health Service, **Selected Home Care References,** 1960 U. S. Gov't. Printing Office, Washington 25, D. C.

*This manuscript includes a comprehensive list of selected readings.
†This report contains an extensive bibliography.